Safety first

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Welcome to this issue of the *Future Healthcare Journal* (*FHJ*).

It's been a busy time for the journal. The transition to being online only has been achieved and we hope you are receiving communications about the issue usefully but not excessively, through email, social media and our website. Downloads of our papers from the website and via PubMed continue to rise and I am equally delighted that submissions continue to be buoyant. Our diverse editorial board (including physician associates; patient and carer representatives; nurses; trainees; and younger and more senior clinicians) provides strategic guidance to myself and the editorial team at the Royal College of Physicians. Despite their other substantial commitments, the board further contributes enthusiastically by writing and managing submissions. I am deeply indebted to them all. Equally I am hugely grateful to our authors and loyal readership. We are always looking to improve the interaction we have with you all, so do feed back to us your thoughts.

The themed articles focus on safety and, in particular, patient-centred safety.

I would like to thank two of our board members, Dr John Dean and Dr Chris Subbe for their work writing and collating the excellent series of articles.

Their separate introduction and editorial provides an overview and further detail, but I would hope we have gone some way to answering the question of how the safety of the care we provide is being impacted by all that has happened in recent times. In the frenzy to provide services and indeed to catch up on the backlog of service provision, it is essential that we continue to provide care that is safe.

In addition to the themed articles, we have our usual eclectic mix of opinion, quality improvement, and education and training. I'm delighted this includes papers from around the world that bring insight and perspective.

The paper from Avik Ray *et al* from Bhopal examines the carbon footprint of our pharmaceutical companies.[1] Objectively measuring the carbon footprint of the healthcare sector is surely necessary if we are to make our contribution to decelerating climate change.

The data presented provide cautious encouragement that these industrial giants are achieving reductions in the net carbon footprint across their activities. We would welcome further papers looking at the carbon footprint of healthcare.

The COVID-19 pandemic continues to be strongly represented in submissions to the *FHJ* matching its continued importance in our lives. A paper from Prathayini Paramanathan *et al* from the USA compares racial health disparities in the 2009 H1N1 pandemic with the current COVID-19 pandemic.[2] The parallels are striking and show that the disparities seen currently are not new phenomena. It reinforces the fact that, while much is novel about the COVID-19 pandemic, there were many lessons in history to help us, too few of which were learnt.

Thinking on patient-centred care, I am often struck by the importance of driving. For many, it is essential to their work and their quality of life. Therefore, clarity of advice regarding driving is a key but too often abbreviated part of clinician–patient communications. So, I am delighted we are publishing a quality improvement project from Tamara Naneishvili *et al* from Hereford Hospital.[3] They introduced a simple 'driving advice template' linked to a programme of education for patients being discharged from hospital after an acute coronary syndrome. This raised provision of accurate advice to over 90% of discharges from a disappointingly low baseline.

I am particularly vexed about the care we offer to our patients towards the end of their lives. We certainly devote a great deal of resource but I'm not sure we achieve best possible patient experience for the patient and their families. I am therefore pleased that we include in this issue two papers that look at aspects of this part of our care.

Zoebia Islam *et al*, in their paper about resuscitation discussions, provide insight into the challenges of these discussions with patients and their families who belong to ethnic minorities.[4] It is shown to be a complex picture and emphasises to me the vital importance of having these discussions before the patient arrives in the emergency room *in extremis*.

Vedamurthy Adhiyaman and Indrajit Chattopadhyay discuss the use of the term 'old age' in death certification.[5] As someone previously researching the epidemiology of heart disease, I have championed diligence in death certification. In an excellent paper, the authors argue against the use of these terms, concerned that it is 'ageist'. But I would offer the thought that in a small but important way, the use of the term 'old age' takes away a very organ-specific view of the end of life, which I hope might reflect a more holistic understanding that some patients are reaching the end of their lives and the care we offer should acknowledge this. Do read the article and decide where you sit in this debate. Publishing such papers that divide opinion is at the heart of what we hope to do through the *FHJ*.

Looking forward, the NHS must continue to focus on improvement. One of the major initiatives is the Getting it Right First Time (GIRFT) programme. This has received considerable funding and resource, and we aim to offer a range of articles that will critically evaluate the impact and successes of this programme and the wider lessons for healthcare change.

In the meantime, do engage with us through our website, by email or via Twitter, and by listening to our podcasts. I hope you find this issue and all our offerings thought-provoking, challenging and, above all, enjoyable. ■

Dr Kevin Fox
Editor-in-chief

References

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